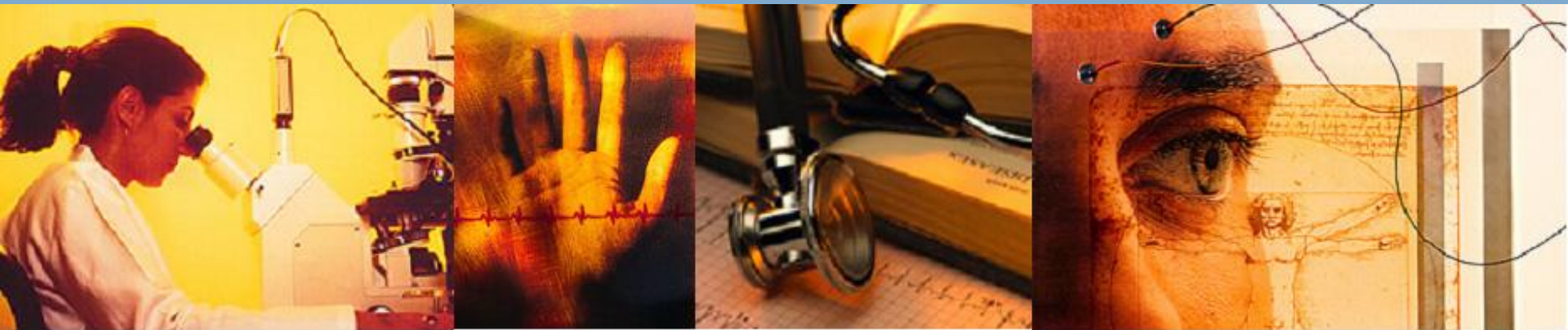




Health I.T.: Understanding Its Value in Transforming Health Care



Discussion Document

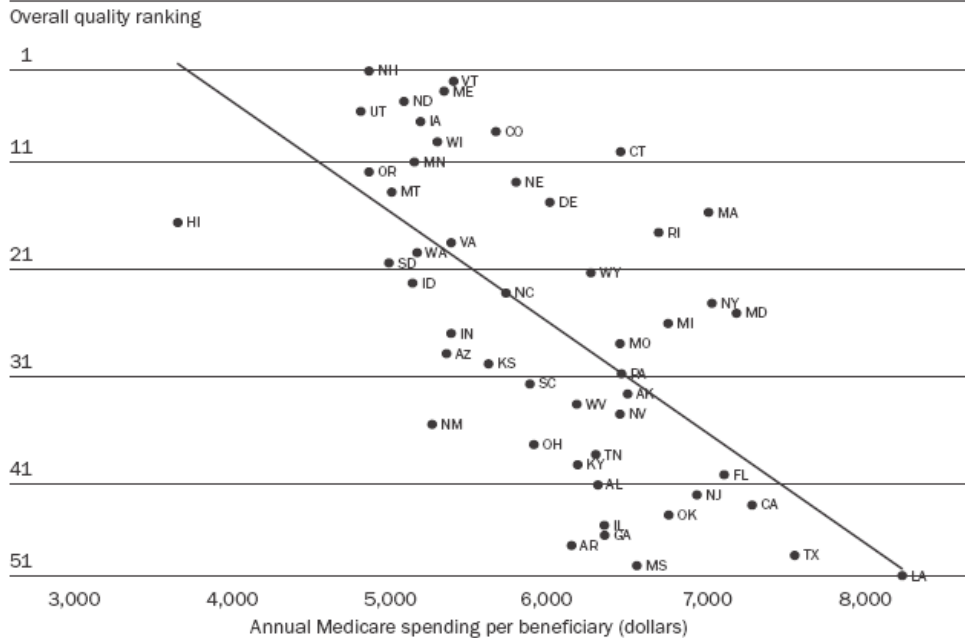
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2/10/09

Spending And Quality Not Linked

Multiple studies indicate the lack of a relationship between spending on health care services and the use of evidence based, high quality care.

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

NOTE: For quality ranking, smaller values equal higher quality.

Health Affairs study⁴ of CMS costs

- Increased spending did not result in increased use of proven, evidence based, effective care or health care quality
- Primary drivers of this challenge felt to be increased use of specialists in high cost areas
- Increased use of specialists highlighted care coordination needs and failure of communication across larger numbers of physicians caring for patients
- Health I.T. is needed as a communication platform to reduce spending via non value added care reductions and increase quality. Key components include:
 - Comprehensive data
 - Real time cognitive decision support
 - Messaging to the physician & patients

WellPoint Approach to Health I.T.:

Improve Health Benefits Value

- By 2010, half of the U.S. population will suffer from a chronic disease
- 83% of health care spending is driven by chronic disease management
- 50-70% of health care spending is related to behaviors

A large gap exists in the care that doctors provide and the care they ought to provide.*

40%

of people with chronic disease don't get recommended care

50%

of people don't receive recommended preventive care

30%

receive contraindicated acute care

20%

receive contraindicated chronic care

- Fundamental improvements in chronic disease management offers a path to managing health care costs and helping Americans stay healthy
- Health I.T. solutions should be judged on their ability to engage end users and influence patient/physician behaviors for quality and efficiency gains

Approach: A Health I.T. Tool Called the IHR



An Easily Deployable Appliance that is scalable and applicable to the vast majority of health care markets

The IHR integrates all clinical and financial data on a regional basis creating a comprehensive clinical and financial record for the patient and the doctor that for the first time delivers broad cognitive support:

- A PHR for the patient
- An E-HR and E-Prescribing for the doctor
- A data exchange infrastructure allowing health coaches, patients and physicians to use a common record
- A rules engine with evidence-based medicine and benefit optimization rules in the system
- Health plan operational rules which drastically reduce pre-auth for admissions, radiology services...



Integrated Health Record (IHR): The Health I.T. Tool with Best Evidence for Value

Continuous Enrolled Study Cohort			
Health IT Non-Users			
	2007	2008	Variance
Allowed Cost	\$ 9,077,150	\$ 11,661,058	28.5%
Mbrs	4126	4126	0.0%
MM	37134	37134	0.0%
Cost PMPM	\$ 244.44	\$ 314.03	28.5%
Avg DXCG		2.13	
Health I.T. Users			
	2007	2008	Variance
Allowed Cost	\$ 1,839,258	\$ 2,226,974	21.1%
Mbrs	666	666	0.0%
MM	5994	5994	0.0%
Cost per Pt	\$ 2,762	\$ 3,344	21.1%
Cost PMPM	\$ 306.85	\$ 371.53	21.1%
Avg DXCG		2.72	

7.5% trend line reduction

.60 higher Risk score

Notes:

1. IHR User defined as at least 3 logins; initial use before 3/31/08
2. Dollars represent allowed cost incurred Jan-Sept each year
3. Excludes pregnancy
4. Excludes catastrophic events
5. Includes members age 18-64 during entire 2 years
6. Includes only members continuously enrolled Jan-Sept both years
7. Excludes members with no claims generated
8. Excludes pharmacy

WellPoint has completed multiple pilots in Ohio, New Hampshire, and nationally. Only E-Prescribing and the IHR have any evidence of impact to trend or improved quality.

WellPoint has partnered with Kettering Health Network in Dayton Ohio to measure cost and quality impacts at the employer group level using the IHR technology.

Operating results over two years show the IHR has preferentially attracted users with higher illness burdens and resulted in a reduced trend line compared with non users despite the higher illness burden

Utilization of the IHR– Sufficient for Value

YTD Registration:

- Employees: 3098 70%
- Dependents: 456 15%
- Total*: 3554 48%

Frequency of Use:

As of 12/3/2008

Excludes Support Users & Physicians

Sign On Frequency	%Users
1-5	54.42%
6-10	30.78%
11-15	9.15%
16-20	3.55%
21-25	1.18%
26-30	0.26%
31-35	0.26%
36-40	0.13%
41-45	0.13%
46-50	0.09%
56-60	0.04%

The IHR has had high rates of utilization with approximately 70% of employees exposed to the tool making use of it.

Further, the IHR has created sufficient value to patients such that over 40% have made use of the tool 6 times or more

Based on these observations, WellPoint is currently expanding the IHR to other employer groups around the country.

Utilization By Service Type

IHR Users-Utilization By Service Type						
		Claims	Cost	Cost/Claim	Claim/Patient	Cost/Patient
Inpatient	2006	104	\$582,443.80	\$5,600.42	0.08	\$440.91
	2007	68	\$600,453.85	\$8,830.20	0.05	\$410.99
	2008	85	\$638,655.80	\$7,513.60	0.05	\$394.96
	08 vs 07					
	Variance	25.0%	6.4%	-14.9%	12.9%	-3.9%
Outpatient	2006	8396	\$1,893,981.86	\$225.58	6.36	\$1,433.75
	2007	3493	\$1,453,776.95	\$416.20	2.39	\$995.06
	2008	3983	\$1,719,323.02	\$431.67	2.46	\$1,063.28
	08 vs 07					
	Variance	14.0%	18.3%	3.7%	3.0%	6.9%
Physician	2006	9912	\$976,368.29	\$98.50	7.50	\$739.11
	2007	13167	\$1,527,823.28	\$116.03	9.01	\$1,045.74
	2008	14773	\$1,786,397.54	\$120.92	9.14	\$1,104.76
	08 vs 07					
	Variance	12.2%	16.9%	4.2%	1.4%	5.6%

Non-IHR Users-Utilization By Service Type						
		Claims	Cost	Cost/Claim	Claim/Patient	Cost/Patient
Inpatient	2006	418	\$2,297,016.46	\$5,495.25	0.08	\$461.43
	2007	318	\$2,342,010.65	\$7,364.81	0.07	\$489.04
	2008	345	\$2,689,772.11	\$7,796.44	0.07	\$569.26
	08 vs 07					
	Variance	8.5%	14.8%	5.9%	10.0%	16.4%
Outpatient	2006	26148	\$5,257,051.68	\$201.05	5.252711933	\$1,056.06
	2007	7578	\$3,278,032.11	\$432.57	1.58	\$684.49
	2008	7855	\$3,788,102.47	\$482.25	1.66	\$801.71
	08 vs 07					
	Variance	3.7%	15.6%	11.5%	5.1%	17.1%
Physician	2006	31068	\$3,057,780.65	\$98.42	6.24	\$614.26
	2007	34785	\$4,166,344.13	\$119.77	7.26	\$869.98
	2008	35351	\$4,467,226.12	\$126.37	7.48	\$945.44
	08 vs 07					
	Variance	1.6%	7.2%	5.5%	3.0%	8.7%

: The IHR produces Significant Improvements in Preventive and Evidence-Based Care

Measure	IHR User	IHR Non User	Difference
Colonoscopy	41.50%	25.60%	15.90%
Mammogram	10.50%	-11.20%	21.70%
Pap Smear	12.70%	0.80%	11.90%
PSA	62.50%	24.40%	38.10%
LdL Test	21.70%	1.10%	20.60%
Hemoglobin A1C	13.90%	2.30%	11.60%
Measured in year over year change			

Note:

E-Prescribing goes live for IHR in Q2-2008 And we will apply our existing measures to evaluate proof of value.







Pct.of Diabetics getting their LDL test

	IHR Users	Non-IHR Users
2006	68%	60%
2007	83%	77%
2008	80%	76%

Quality gains were achieved despite IHR users having a higher illness burden and an improved trend line.

This is the only example we know of where Health I.T. is delivering on its potential—better use of evidence based clinical knowledge, lower cost of care for more complexly ill members, and improved prevention.

Value Proposition Vs. RHIOs

Value	IHR	RHIOs
<u>Improved patient compliance</u> due to a single record that both the patient and physician add to and can view as needed		
<u>Improved care quality & preventive health</u> via better adherence to evidence based care via an ontology and a real time rules engine		
Foundation for <u>reduced admin costs and reduced physician abrasion</u> via automated care management processes and messaging		
<u>Increase drug safety and reduce the cost of prescribing</u> via electronic prescribing capabilities integrated with the IHR		
<u>Reductions in privacy and security concerns</u> via direct access control of the record by the patient and transparency as to who accessed the record		
<u>Analytics that identify new opportunities to improve care</u> via analysis of data generated from clinical data sharing infrastructure		
<u>Improvements in physician productivity</u> via real time patient data, evidence based medicine algorithms and physician messaging	